


Understanding Montana Workers' Compensation (WC) Facility Fee Schedule UNIT TWO: USING THE UB-04

New updates of information, similar to FAQ, will be added to this educational module on a regular basis, so please check the date at the bottom of this page regularly to keep up with additional fee schedule information.

A Power Point educational module created by the Montana Department of Labor (DLI) in March, 2009. Actual regulations in the Administrative Rules of Montana, of course, take precedence in case of any misstatements in this educational module.

March 19, 2009



Unit Two: Using The UB-04: Billing Forms for the Montana MS-DRG (inpatient) and APC (outpatient) Facility Fee Schedule

**For use with the Montana Facility Fee Schedule for Workers'
Compensation (WC) Reimbursement**

What You Need To Do First

This educational module is designed based on the assumption that you have already learned the materials in **Unit One: Essential Information about the Montana Facility Fee Schedules for Workers' Compensation Insurance.**

Unit One is located on this same state web page, so you should be able to find it easily and master its contents before beginning this second unit.

Educational Module Organization

- **Section One: Locating required Information on the UB-04 Form**
- **Section Two: Examples of Processing Inpatient (MS-DRG) Bills**
- **Section Three: Examples of Processing Outpatient (APC) Bills**
- **Section Four: Other Ways of Paying**
- **Section Five: Other Resources**

Get Ready to Process UB-04s

- **Unit One** introduced you to the Grouper/Pricer concept for determining MS-DRGs and APCs, and gave a few examples of the billing process for the Montana WC reimbursement system.
- This **Unit Two** provides multiple examples of how to process the bill for payment. If, after working through all these examples, you still cannot complete a particular bill, please send us an email at wwilkison@mt.gov and we will attempt to help you. Meanwhile, for correlation purposes over the next few slides discussing portions of the UB-04 form, the very next slide is an image of the UB-04 form as a whole.

This is an image of the UB-04 Form

[illegible]

What does the UB-04 form tell me?

Is It An Inpatient or Outpatient Bill?

Remember that a bill from a hospital facility can be for either inpatient or outpatient services, so be sure to confirm that the code entered into **Block 4** on the upper right corner of the UB-04 form is either

- 0111 (inpatient services, for which you use a MS-DRG Grouper) or
- 0131 (outpatient services, for which you use the APC codes and process, as described later in this learning module)
- There are quite a few other codes that can be entered in Block 4, but most may be payable at one of the 75 percent reimbursement rates described in Section Four of this learning module

Right Upper Corner of UB-04, Block 4

	3a PAT. CNTL #							Block 4	
	b. MED. REC. #								
	5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM		THROUGH		7			
		c	d	e					
DITION CODES		29 AGDT		30					
23	24	25	26	27	28	STATE			
REFERENCE SPAN		36		OCCURRENCE SPAN		37			
M	THROUGH	CODE	FROM	THROUGH					

Does Block 4 include 111, 131, or another code?

Where do we find the required claimant information?

- **Patient information (age, sex, discharge status) is in the upper left corner**
- **Medical information (Diagnosis & Procedures) is in the lower left corner**

Required Patient Status Information is in the upper left portion of the UB-04

1										2									
8 PATIENT NAME										9 PATIENT ADDRESS									
a										a									
b										b									
10 BIRTHDATE										11 SEX									
12 DATE										13 HR 14 TYPE 15 SRC									
16 DHR										17 STAT									
10 Birthdate; 11 Sex										17 Discharge Status									
31 OCCURRENCE CODE DATE										33 OCCURRENCE CODE DATE									
35 CODE										35 CODE									
38																			

D & P Codes are Located in the Lower Left Corner of the UB-04

63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER																								
A																																		
B																																		
C																																		
<div style="border: 2px solid black; padding: 5px; display: inline-block;"> <table border="1" style="width: 100%;"> <tr> <td>66 DX</td> <td>67</td> <td colspan="12">Find D(iagnosis) codes here</td> <td>E</td> </tr> </table> </div>																				66 DX	67	Find D(iagnosis) codes here												E
66 DX	67	Find D(iagnosis) codes here												E																				
69 ADMIT DX						70 PATIENT REASON DX		a	b	c	71 PPS CODE				72 ECI																			
74		PRINCIPAL PROCEDURE								b.		OTHER PROCEDURE				75																		
		CODE				DATE						CODE				DATE																		
<div style="border: 2px solid black; padding: 5px; display: inline-block;"> <table border="1" style="width: 100%;"> <tr> <td colspan="4"></td> <td colspan="4">Find P(rocedure) codes here</td> <td colspan="4"></td> </tr> </table> </div>																								Find P(rocedure) codes here										
				Find P(rocedure) codes here																														
80 REMARKS										81CC																								
										a																								
										b																								

From the UB-04 to the Grouper

- Now that we know where to find the required UB-04 data to enter into a Grouper, let's go over the use of the MS-DRG Grouper
- First, open up the free Grouper at www.hospitalbenchmarks.com so that we can generate a corresponding Medicare Severity-Diagnosis Related Group (MS-DRG) classification code

Summary from Unit One On the Use of the Grouper

Using an MS-DRG Grouper with a UB-04 (see the sample UB-04 and Grouper form on the next three slides):

- 1) Enter Patient information from the UB-04 onto the first page of the Grouper**
- 2) Identify the Diagnosis (D) and Procedure (P) Codes on the UB-04, & proceed only if Block 4 includes code 0111 (which equates to inpatient services)**
- 3) Insert the D & P Codes in the order, left to right, as they appear on the UB-04, into the correct cells on the Grouper. As you enter the D & P codes, remember to not include the decimal. Once you have all codes inputted, press the “Group & Compare” button. Remember also that the number of cells (or blocks) available on the Grouper for input represent the maximum number of D&P codes that create the MS-DRG code.**
- 4) Confirm the reimbursement amount cited by the Grouper-generated MS-DRG code with the Montana Facility Fee Schedule section listing that MS-DRG code. Note also that Montana uses a rounding whole dollar reimbursement calculation for the MS-DRG reimbursement.**

Example #1: Enter the medical data (D & P) from the lower left-hand corner of the UB-04 into the Grouper

63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER													
A																							
B																							
C																							
66 DX	75612			3051			E8889			4019			25000			41400							
	7806			7850			2859																
69 ADMIT DX				70 PATIENT REASON DX	a			b			c			71 PPS CODE				72 ECI					
74 PRINCIPAL PROCEDURE CODE DATE								b. OTHER PROCEDURE CODE DATE				75											
8108				072909				8162				072909				8451				072909			
								d. OTHER PROCEDURE CODE DATE															
80 REMARKS										81CC a													
										b													

Example #1 in the Grouper (page 1 of 2)

INGENIX. Hospital

financial benchmarks participating hospitals »

Username:

Password:

Login

► Web Based MS-DRG
Grouper →

Online and clinical information for hospital industry

To compete in the industry, it is important for care organizations to have accurate information. It is a customized service that provides reliable and accurate information that you can make use of to improve your performance.

Age: Sex: F ▼ Discharge Status: 01 - Home, Self Care ▼

Diagnosis Codes (Do not enter with decimal points):

Procedure Codes (Do not enter with decimal points):

GROUP & COMPARE ↑ Reset

Example #1 in the Grouper (page 2 of 2)

Diagnosis Codes (Do not enter with decimal points):

75612 3051 e8889 4019 25000 41400 7806 7850 2859

Procedure Codes (Do not enter with decimal points):

8108 8162 8451

GROUP & COMPARE

Reset

Grouping Results:

CMS v24 DRG Assignment:	498 (SPINAL FUSION EXCEPT CERVICAL W/O CC)	[Pre MS-DRG year
CMS v25 (MS) DRG Assignment:	460 (SPIN FUS EXC CERV WO MCC)	Last year MS-DRG
CMS v26 (MS FY2009) DRG Assignment:	460 (SPIN FUS EXC CERV WO MCC)	Current year MS-DRG]
MDC:	08 (Diseases & Disorders Of The Musculoskeletal System & Conn Tissue)	
CMS v24 DRG Weight:	2.9896	
CMS v25 (MS) DRG Weight:	3.4870	
CMS v26 (MS FY2009) DRG Weight:	3.5607	
CC Diagnosis:	None	
MCC Diagnosis:	None	
*	Updated to CMS final rule.	

Example # 1: Working through the process

- For this **claim example #1**, MS-DRG 460 not only identifies the MS-DRG to be used but also can be used to identify the reimbursement amount. (The Grouper will also provide the MS-DRG weight of 3.5607 for the current version (26) of the MS-DRG calculation, but usually you will not need to deal with these kinds of details) If you are interested in the mechanics of the calculation, the MS-DRG weight (3.5607) is multiplied by the Montana Base rate (\$7,735) = \$27,542.
- MS-DRG 460 is reimbursed by the Montana Facility Fee Schedule at \$27,542. You can find both the MS-DRG code and its reimbursement amount in “(a) The Montana Hospital Inpatient Services MS-DRG Reimbursement Fee Schedule” portion of the Montana Facility Fee Schedule, which is located on the Montana Department of Labor’s web page at <http://erd.dli.mt.gov/wcstudyproject/MFFS%20pdf/a%20MSDRG%20V26.xls>

MS-DRG claim example # 2: Example assumes patient data is already entered into Grouper, and that Block 4 data = 0111. Now enter the appropriate medical codes listed below into the Grouper.

63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER																										
A																																				
B																																				
C																																				
66 DX	8080					A					B					C					D					E										
						J					K					L					M					N										
69 ADMIT DX						70 PATIENT REASON DX	a					b					c					71 PPS CODE						72 ECI								
74	PRINCIPAL PROCEDURE CODE					DATE										b.					OTHER PROCEDURE CODE					DATE					75					
	7939					092309					9339					092409																				
										d.					OTHER PROCEDURE CODE					DATE																
80 REMARKS																				81CC																
																				a																
																				b																

For example # 2, the MS-DRG is 517, which according to “(a) The Montana Hospital Inpatient Services MS-DRG Reimbursement Fee Schedule,” should be reimbursed at \$10,282

Age: Sex: Discharge Status:

Diagnosis Codes (Do not enter with decimal points):

Procedure Codes (Do not enter with decimal points):

Grouping Results:

CMS v24 DRG Assignment:	234 (OTH MUSCSKL & CONN TISS O.R. PROC W/O CC)	[Pre MS-DRG year
CMS v25 (MS) DRG Assignment:	517 (OTH MSSKEL SYS&CONN TISS OR PX W/O CC/MCC)	Last year MS-DRG
CMS v26 (MS FY2009) DRG Assignment:	517 (OTH MSSKEL SYS&CONN TISS OR PX W/O CC/MCC)	Current year MS-DRG]
MDC:	08 (Diseases & Disorders Of The Musculoskeletal System & Conn Tissue)	
CMS v24 DRG Weight:	1.2565	
CMS v25 (MS) DRG Weight:	1.4192	
CMS v26 (MS FY2009) DRG	1.3293	

Example # 2: Working through the process

- For this **claim example # 2**, MS-DRG 517 not only identifies the MS-DRG to be used but also can be used to identify the reimbursement amount.
- MS-DRG 517 is reimbursed by the Montana Facility Fee Schedule at \$10,282. You can find both the MS-DRG code and its reimbursement amount in “(a) The Montana Hospital Inpatient Services MS-DRG Reimbursement Fee Schedule” portion of the Montana Facility Fee Schedule, which is located on the Montana Department of Labor’s web page at <http://erd.dli.mt.gov/wcstudyproject/MFFS%20pdf/a%20MSDRG%20V26.xls>

MS-DRG claim example # 3: Example assumes patient data is already entered into Grouper, and that Block 4 data = 0111. Now enter the appropriate medical codes listed below into the Grouper.

63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER																													
A																																							
B																																							
C																																							
66 DX	67					A					B					C					D					E													
	8851					4779					3051																												
69 ADMIT DX						70 PATIENT REASON DX					a					b					c					71 PPS CODE					72 ECI								
74					PRINCIPAL PROCEDURE CODE					DATE										b.					OTHER PROCEDURE CODE					DATE					75				
					8622					060409					8401					060409					8673					060409									
															d.					OTHER PROCEDURE CODE					DATE														
					8659					060409					8401					060409					8401					060409									
80 REMARKS															81CC a																								
															b																								

Example # 3: in this example, the MS-DRG is 903, which according to “(a) The Montana Hospital Inpatient Services MS-DRG Reimbursement Fee Schedule,” should be reimbursed at \$7,742

8851 4779 3051

Procedure Codes (Do not enter with decimal points):

8622 8673 8659 8401

GROUP & COMPARE **Reset**

Grouping Results:

CMS v24 DRG Assignment:	440 (WOUND DEBRIDEMENTS FOR INJURIES)	[Pre MS-DRG year
CMS v25 (MS) DRG Assignment:	903 (WD DBRD FOR INJURIES WO CC/MCC)	Last year MS-DRG
CMS v26 (MS FY2009) DRG Assignment:	903 (WD DBRD FOR INJURIES WO CC/MCC)	Current year MS-DRG]
MDC:	21 (Injuries, Poisonings & Toxic Effects Of Drugs)	
CMS v24 DRG Weight:	1.9291	
CMS v25 (MS) DRG Weight:	1.4966	
CMS v26 (MS FY2009) DRG Weight:	1.0009	
CC Diagnosis:	None	
MCC Diagnosis:	None	

Internet

Example # 3: Working through the process

- For this **claim example # 3**, MS-DRG 903 not only identifies the MS-DRG to be used but also can be used to identify the reimbursement amount.
- MS-DRG 903 is reimbursed by the Montana Facility Fee Schedule at \$7,742. You can find both the MS-DRG code and its reimbursement amount in “(a) The Montana Hospital Inpatient Services MS-DRG Reimbursement Fee Schedule” portion of the Montana Facility Fee Schedule, which is located on the Montana Department of Labor’s web page at <http://erd.dli.mt.gov/wcstudyproject/MFFS%20pdf/a%20MSDRG%20V26.xls>

MS-DRG claim example # 4: Example assumes patient data is already entered into Grouper, and that Block 4 data = 0111. Now enter the appropriate medical codes listed below into the Grouper.

63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER																										
A																																				
B																																				
C																																				
66 DX	8080					A					B					C					D					E										
						J					K					L					M					N										
69 ADMIT DX						70 PATIENT REASON DX	a					b					c					71 PPS CODE						72 ECI								
74	PRINCIPAL PROCEDURE CODE					DATE										b.					OTHER PROCEDURE CODE					DATE					75					
	7939					0602009					9339					060209					8703					053009										
										d.					OTHER PROCEDURE CODE					DATE																
80 REMARKS																				81CC																
																				a																
																				b																

Example # 4: in this example, the MS-DRG is 512, which according to
[a) The Montana Hospital Inpatient Services MS-DRG Reimbursement
Fee Schedule,” should be reimbursed at \$7,355

Age: Sex: Discharge Status:

Diagnosis Codes (Do not enter with decimal points):

Procedure Codes (Do not enter with decimal points):

GROUP & COMPARE **Reset**

Grouping Results:

CMS v24 DRG Assignment:	224 (SHLDR,ELBW,FOREARM PROC,EX MAJ JNT WO CC)	[Pre MS-DRG year
CMS v25 (MS) DRG Assignment:	512 (SHLDR,ELBW,FORARM PX EXC MJ JT WO CC/MCC)	Last year MS-DRG
CMS v26 (MS FY2009) DRG Assignment:	512 (SHLDR,ELBW,FORARM PX EXC MJ JT WO CC/MCC)	Current year MS-DRG]
MDC:	08 (Diseases & Disorders Of The Musculoskeletal System & Conn Tissue)	
CMS v24 DRG Weight:	0.8574	
CMS v25 (MS) DRG Weight:	0.9602	
CMS v26 (MS FY2009) DRG Weight:	0.9509	
CC Diagnosis:	None	

Example # 4: Working through the process

- For this **claim example # 4**, MS-DRG 512 not only identifies the MS-DRG to be used but also can be used to identify the reimbursement amount.
- MS-DRG 512 is reimbursed by the Montana Facility Fee Schedule at \$7,355. You can find both the MS-DRG code and its reimbursement amount in “(a) The Montana Hospital Inpatient Services MS-DRG Reimbursement Fee Schedule” portion of the Montana Facility Fee Schedule, which is located on the Montana Department of Labor’s web page at <http://erd.dli.mt.gov/wcstudyproject/MFFS%20pdf/a%20MSDRG%20V26.xls>

MS-DRG claim example # 5: Example assumes patient data is already entered into Grouper, and that Block 4 data = 0111. Now enter the appropriate medical codes listed below into the Grouper.

63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER																																																																																									
A																																																																																																			
B																																																																																																			
C																																																																																																			
66 DX	8080					81341					83500					E8282					V078					187343																																																																									
J																				K																				L																				M																				N																			
69 ADMIT DX										70 PATIENT REASON DX					a					b					c					71 PPS CODE										72 ECI																																																											
74					PRINCIPAL PROCEDURE CODE					DATE										b.					OTHER PROCEDURE CODE					DATE					75																																																																
					7932					060209					7939					060209					387					060209																																																																					
										d.					OTHER PROCEDURE CODE					DATE																																																																															
					8703					053009																																																																																									
80 REMARKS															81CC a																																																																																				
															b																																																																																				

For example # 5, the MS-DRG is 511, which according to “(a) The Montana Hospital Inpatient Services MS-DRG Reimbursement Fee Schedule,” should be reimbursed at \$10,359.

Age: Sex: Discharge Status:

Diagnosis Codes (Do not enter with decimal points):

Procedure Codes (Do not enter with decimal points):

GROUP & COMPARE

Reset

Grouping Results:

CMS v24 DRG Assignment:	224 (SHLDR,ELBW,FOREARM PROC,EX MAJ JNT W O CC)
CMS v25 (MS) DRG Assignment:	511 (SHLDR, ELBW, FORARM PX EXC MAJ JT W CC)
CMS v26 (MS FY2009) DRG Assignment:	511 (SHLDR, ELBW, FORARM PX EXC MAJ JT W CC)
MDC:	08 (Diseases & Disorders Of The Musculoskeletal System & Conn Tissue)
CMS v24 DRG Weight:	0.8574
CMS v25 (MS) DRG Weight:	1.2512

[Pre MS-DRG year

Last year MS-DRG

Current year MS-DRG]

Example # 5: Working through the process

- For this **claim example # 5**, MS-DRG 511 not only identifies the MS-DRG to be used but also can be used to identify the reimbursement amount.
- MS-DRG 511 is reimbursed by the Montana Facility Fee Schedule at \$10,359. You can find both the MS-DRG code and its reimbursement amount in “(a) The Montana Hospital Inpatient Services MS-DRG Reimbursement Fee Schedule” portion of the Montana Facility Fee Schedule, which is located on the Montana Department of Labor’s web page at <http://erd.dli.mt.gov/wcstudyproject/MFFS%20pdf/a%20MSDRG%20V26.xls>
- **There is a new element in this bill**, namely that the bill charges on the UB-04 total \$41,092, which is more than three times the MS-DRG normal reimbursement amount of \$10,359, so **this claim example is likely to be an outlier.**

Example # 5 (continued)

Inpatient Outliers

The MS-DRG system is intended to meet the majority of all inpatient reimbursement needs

Occasionally very high medical costs associated with a particular case, known as outlier costs, may require additional reimbursement to the facility

Example # 5 (continued)

Calculating Outlier Payments

- Charges must meet the outlier threshold formula established by the Administrative Rules of Montana (ARM) for inpatient outlier costs
- The threshold formula is the MS-DRG payment multiplied by 3
- $[\text{Charges} - (\text{MS-DRG payment} \times 3)] \times (\text{RCC plus } 15\%)$
- There is a different RCC (Ratio of Cost-to-Charge) for each Montana Hospital (for the RCCs, see “(f) The Montana RCC and other Montana RCC-based Calculations” section of the Montana Facility Fee Schedule)

The Ratio of Costs-to-Charges for Each Hospital are listed on “(f) The Montana RCC and other Montana RCC-based Calculations” section of the Montana Facility Fee Schedule, located on our webpage

(f) The Montana RCC and other Montana RCC-based Calculations					
The table below lists the 14 regulated (acute care and long-term care) hospitals in Montana and their RCCs (Ratio of Costs to Charges) in 2008. These RCCs are based on research and analysis conducted by the Centers for Medicare and Medicaid Services (CMS), utilizing financial reports submitted by each of the hospitals.					
When claim outliers are calculated, the individual hospital's RCC will be used as the basis in calculations.					
Reimbursement rates in this fee schedule remain unchanged until the next revision of this fee schedule section referenced in the <u>Administrative Rules of Montana</u> .					
		CMS' 2008			
		Calculation			
		of Individual			
		Facility			
		Cost to			
Hospital	CMS	Charge			
Name	Provider Number	Ratios	Notes:		
ADVANCED CARE HOSPITAL OF MONTANA			1) Advanced Care Hospital of Montana in Billings had not yet been given an RCC or CMS provider number at the time this data table was developed.		
BENEFIS HEALTHCARE	270012	0.416			
BOZEMAN DEACONESS HEALTH SERVICES	270057	0.533			
CENTRAL MONTANA MEDICAL CENTER	270011	0.566			
COMMUNITY MEDICAL CENTER	270023	0.522	2) Sources for the data table include a number of CMS database report sections, particularly "HCRIS 2005 Report of Total Costs, IP Charges and		
BILLINGS CLINIC	270004	0.371	Inpatient Charges from Worksheet C, Part I, Line 101, Column 5,		
HEALTHCENTER NORTHWEST	270087	0.838	6, and 7," et. seq., HCRIS' CostsCharges0907, subset "2005		
HOLY ROSARY HEALTH CENTER	270002	0.416	Hospital Complex Total Costs and Charges," et. seq., and		
KALISPELL REGIONAL MEDICAL CENTER	270051	0.443	"Hospital2007_09_07 FY2005" et. seq.		
NORTHERN MONTANA HOSPITAL	270032	0.418			
SAINT JAMES COMMUNITY HOSPITAL	270017	0.454			
ST. PATRICK HOSPITAL	270014	0.377			
ST. PETERS HOSPITAL	270003	0.427			
SAINT VINCENT HEALTHCARE	270049	0.377			

Example # 5 (continued)

Calculating the outlier for Billings Clinic:

- **Medical charges total \$41,092,**
- **And the MS-DRG Payment is \$10,359,**
- **And the outlier threshold is \$31,077,**
- **And the RCC (Ratio of Cost-to-Charge) is 0.371,**
- **Then the outlier payment = $(\$41,092 - (\$10,359 \times 3)) \times (0.371 + .15) = \$5,217$ to be added to the regular reimbursement**
- **Therefore total payment is $\$10,359 + \$5,217 = \$15,577$**

Other Considerations

Pay the Bill based on the Fee Schedule

**MS-DRG rates are based on a “case mix” formula,
so insurers should pay the actual fee schedule
reimbursement amount, instead of a higher or
lower reimbursement amount the medical
provider might bill**

Section Three: Utilizing the UB-04 to Reimburse Outpatient (APC) Bills

Is It An Inpatient or Outpatient Bill?

Remember that a bill from a hospital facility can be for either inpatient or outpatient services, so be sure to confirm that the code entered into **Block 4** on the upper right corner of the UB-04 form is either

- 0111 (inpatient services, for which you use a MS-DRG Grouper as you have just learned above) or
- 0131 (outpatient services, for which you use the APC codes and process, as we will now describe in this learning module). Remember also that the APC reimbursement system is also used by Ambulatory Surgery Centers (ASCs) for billing and reimbursement purposes, so ASC bill information also follows this APC billing process
- There are quite a few other facility-related codes that can be entered in Block 4, but most may be payable at one of the 75 percent reimbursement rates described below in Section Four of this learning module

Upper Right Corner of UB-04, Block 4

3a PAT. CNTL #									
b. MED. REC. #									
		Block 4							
5 FED. TAX NO.				6 STATEMENT COVERS PERIOD FROM				7 THROUGH	
				c		d		e	
DITION CODES				29 ACDT		30			
23		24		25		26		27	
REFERENCE SPAN				36 CODE				37	
M				THROUGH				THROUGH	

Does Block 4 include 111, 131, or another code?

The APC Process is more manual: Finding the Matching CPT/APC Codes

- If the UB-04 has code 131 in Block 4, you are all set to process the Outpatient billing
- **Step 1:** Look up the “Principal Procedure” (PP) code in cell # 74 of the D & P portion of the UB-04, and then compare that PP code to the CPT codes in the “(c) The Montana Hospital Outpatient and ASC Fee Schedule Organized by CPT/HCPCS” section of the Montana Facility Fee Schedule

63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER												
A																						
B																						
C																						
66 DX	67 T	A	B	C	D	E																
69 ADMIT	70 PATIENT			a	b	c	71 PPS CODE	72 ECI														
74		PRINCIPAL PROCEDURE CODE				DATE				b.				OTHER PROCEDURE CODE				DATE				75
80 REMARKS										81CC												
										a												
										b												

74 Principal Procedure

The APC Process is more manual: Finding the Reimbursement Value of the APC Code

- **Step 2:** With the APC code identified, use “(b) The Montana Hospital Outpatient and ASC Fee Schedule Organized by APC” of the Montana Facility Fee Schedule to determine the APC reimbursement amount. Remember to select either the “Hospital APC Payment” or “ASC APC Payment” column to properly pay the facility’s APC reimbursement.
- **Step 3:** Return to the non-principal Procedure codes on the UB-04 and identify their respective Status Indicator (SI) codes by looking them up in the “(c) The Montana Hospital Outpatient and ASC Fee Schedule Organized by CPT/HCPCS” section of the Montana Facility Fee Schedule
- Each Status Indicator code will assist you in determining whether the individual non-principal Procedure codes are to be paid separately, are discounted, or are “built into” the APC reimbursement amount already determined for the Principal Procedure code.

The APC Process is more manual: Finding the Reimbursement Value of the Remaining CPT codes via Status Indicator codes

The “(c) The Montana Hospital Outpatient and ASC Fee Schedule Organized by CPT/HCPCS” fee schedule listing includes an entire column (second from left) with Status Indicator (SI) codes

CPT & HCPCS Codes	Status Indicator codes	APC	Relative Weight	Montana Hospital APC Payment	Montana ASC APC Payment
96900	S	0001	0.4806	\$50.46	\$37.97
96910	S	0001	0.4806	\$50.46	\$37.97
96912	S	0001	0.4806	\$50.46	\$37.97
10021	T	0002	1.1097	\$116.52	\$87.67
19001	T	0002	1.1097	\$116.52	\$87.67
36680	T	0002	1.1097	\$116.52	\$87.67
G0364	T	0002	1.1097	\$116.52	\$87.67
38220	T	0003	3.1008	\$325.58	\$244.96
38221	T	0003	3.1008	\$325.58	\$244.96
10022	T	0004	4.3270	\$454.34	\$341.83
19000	T	0004	4.3270	\$454.34	\$341.83

SI codes let you determine how to reimburse non-principal Procedure codes, and are described for you on “(g) The Montana Status Indicator Codes” section of the Montana Facility Fee Schedule

(g) The Montana Status Indicator (SI) Codes

Each APC, CPT and HCPCS code has been assigned a letter that signifies whether the Montana Facility Fee Schedule will reimburse the service and how it will be reimbursed. The indicator also helps in determining whether policy rules, such as packaging and discounting, apply. Only Montana Status Indicator codes can be used to calculate reimbursements for services and supplies. Ignore status indicator codes other than A, B, D, F, G, H, K, L, N, P, S, T and X and pay at the fee scheduled amount listed.

SI Code	SI (Status Indicator) Description
A	Fee Schedules:[reimburse] Ambulance[-related codes only].
B	Non-allowed item or service. Not a hospital service.
D	Discontinued code.
F	Acquisition costs paid for Corneal tissue acquisition; certain CRNA services and hepatitis B vaccines.
G	Additional payment for Drug/Biological pass-through.
H	Additional payment for Pass-through device categories, brachytherapy sources, and radiopharmaceutical agents.
K	[Not a] Pass-through [for] drugs [, devices] and biologicals [These are to be paid separately from the APC].
L	Flu and other vaccines.
N	No additional payment, payment included in line items with APCs for incidental service. (Packaged codes not paid separately).
P	Paid Partial hospitalization per diem payment.
S	Significant procedure not subject to multiple procedure discounting.
T	Significant procedure, subject to 50% discount on second procedure if present.
X	Ancillary services.
1) Please note the misprint for SI "K" corrected hereon with bracketed text	
2) Please note the clarification for SI "A" corrected hereon with bracketed text	

Status Indicator codes in Summary:

Montana Status Indicator (SI) codes

- **Apply to outpatient services only**
- **Also help identify how APCs and other codes are reimbursed**

Only Montana Status Indicator codes can be used to calculate reimbursements for services and supplies

Ignore status indicator codes other than A, B, D, F, G, H, K, L, N, P, S, T and X, and pay at the fee scheduled amount listed

Please note that:

- **SI “A” should only be reimbursed for ambulance-related services, for example stand-by waiting and other services listed on “(d) The Montana Ambulance Fee Schedule” within the Montana Facility Fee Schedule**
- **SI “K” on the “(g) Status Indicator (SI)” portion of our fee schedule is mislabeled and should instead state “not a pass-through drug or device, and needs to be paid separately from the APC”**

Other Useful APC Facts

Outpatient services are grouped into APCs

- **There may be several APCs per patient per day**
- **There may be discounts for multiple APCs**
- **There may be separately payable CPT and HCPCS services**
- **Montana CCI (Correct Coding Initiative) edits further assist insurers to understand how to reimburse when multiple codes are involved**

APC reimbursement levels are different for ASCs and Hospitals

- The basic formula for outpatient reimbursement is the Montana Base Rate times the APC relative weight of a given APC
- For hospitals, the Montana Base Rate is \$105 beginning 12/01/08
- For ASCs, the Montana Base Rate is \$79 beginning 12/01/08
- If no rate is listed and the code is not otherwise included in the Montana Facility Fee Schedule or the Administrative Rules of Montana, the service is to be paid at 75% of the Montana usual & customary charge*

*In Montana “usual and customary” means the provider’s normal charges for a service, and does not include state or regional database information purporting to be usual and customary

Reimbursing (APC) Outpatient Bills: APC Example # 1

APC Example # 1 (with a Block 4 code of 131) is a hospital outpatient service.

63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER																																		
A																																												
B																																												
C																																												
66 DX	33829					A					B					C					D					E																		
					J					K					L					M					N																			
69 ADMIT DX					70 PATIENT REASON DX					a					b					c					71 PPS CODE					72 ECI														
74 PRINCIPAL PROCEDURE CODE										DATE										b. OTHER PROCEDURE CODE										DATE										75				
99281										120608																																		
										d. OTHER PROCEDURE CODE										DATE																								
80 REMARKS															81CC a																													
															b																													

Reimbursing (APC) Outpatient Bills: APC Example # 1

- **The Principal Procedure code is 99281, which the “(c) The Montana Hospital Outpatient and ASC Fee Schedule Organized by CPT/HCPCS” of the Facility Fee Schedule as APC 609, and which “(b) the Montana Hospital Outpatient and ASC Fee Schedule Organized by APC” reimburses at \$83.69 for hospital outpatient services**
- **There are no additional CPT/HCPCS codes on the bill, so there are no additional codes to check Status Indicators for additional reimbursements**
- **The entire reimbursement for this claim is therefore \$83.69**

Reimbursing (APC) Outpatient Bills: APC Example # 2

APC Example # 2 (with a Block 4 code of 131) is a hospital outpatient service.

63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER																								
A																																		
B																																		
C																																		
66 DX	9964					A					B					C					D					E								
					J					K					L					M					N									
69 ADMIT DX					70 PATIENT REASON DX					a					b					c					71 PPS CODE					72 ECI				
74 PRINCIPAL PROCEDURE CODE DATE										b. OTHER PROCEDURE CODE DATE										75														
29827 121608										J2250 121608										C1713 121608														
										d. OTHER PROCEDURE CODE DATE																								
80 REMARKS															81CC a																			
															b																			

Reimbursing (APC) Outpatient Bills: APC Example # 2

- The Principal Procedure code is 29827, which the “(c) The Montana Hospital Outpatient and ASC Fee Schedule Organized by CPT/HCPCS” of the Facility Fee Schedule lists as APC 42, and which “(b) the Montana Hospital Outpatient and ASC Fee Schedule Organized by APC” reimburses at \$4,799.26 for hospital outpatient services
- There are 2 additional CPT/HCPCS codes on the bill, so there are 2 additional codes to check Status Indicators (SI) in case additional reimbursements should be made for this claim
- HCPCS J2250 has a SI of N, meaning it is bundled into the APC, so there is no separate, additional reimbursement for the first non-principal procedure CPT/HCPCS
- HCPCS C1713 has a SI of N, meaning it is bundled normally into the APC, so there is no separate, additional reimbursement for the second non-principal procedure CPT/HCPCS either. There is separate methodology for direct reimbursement of costs for implants (that also includes reimbursement for shipping, and an additional payment of 15 percent of cost), so this biller is apparently still gathering together the invoices required to document the additional reimbursement, and will submit the invoices at a later time to the insurer.
- The entire reimbursement for this claim at this time is therefore \$4,799.26.

Reimbursing (APC) Outpatient Bills: APC Example # 3

APC Example # 3 (with a Block 4 code of 131) is an Ambulatory Surgery Center (ASC) outpatient service.

63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER																													
A																																							
B																																							
C																																							
66 DX	67					A					B					C					D					E													
	I					J					K					L					M					N													
69 ADMIT DX						70 PATIENT REASON DX					a					b					c					71 PPS CODE					72 ECI								
74					PRINCIPAL PROCEDURE CODE					DATE										b.					OTHER PROCEDURE CODE					DATE					75				
					29827					120508					29823					120508					29826					120508									
															d.					OTHER PROCEDURE CODE					DATE														
80 REMARKS															81CC a																								
															b																								

Reimbursing (APC) Outpatient Bills: APC Example # 3

- The Principal Procedure code is 29827, which the “(c) The Montana Hospital Outpatient and ASC Fee Schedule Organized by CPT/HCPCS” of the Facility Fee Schedule lists as APC 42, and which “(b) the Montana Hospital Outpatient and ASC Fee Schedule Organized by APC” reimburses at \$3,610.87 for ambulatory surgery center outpatient services
- There are 2 additional CPT/HCPCS codes on the bill, so there are 2 additional codes to check Status Indicators (SI) in case additional reimbursements should be made for this claim
- CPT 29823 has a SI of T, meaning it is a significant procedure subject to a 50 percent discount as a second procedure, so there is a separate, additional reimbursement of \$1,805.43 (\$3,610.87 divided by 50 percent)
- CPT 29826 has a SI of T, meaning it is a significant procedure subject to a 50 percent discount as a second procedure, so there is a separate, additional reimbursement of \$1,805.43 (\$3,610.87 divided by 50 percent).
- There is separate methodology for direct reimbursement of costs for implants (that also includes reimbursement for shipping, and an additional payment of 15 percent of cost), so this biller is apparently still gathering together the invoices required to document the additional reimbursement, and will submit the invoices and bill for the implant at a later time to the insurer.
- The entire reimbursement for this claim at this time is therefore \$7,221.74 (\$3,610.87+\$1,805.43+\$1,805.43).

Other Considerations

Pay the Bill based on the Fee Schedule

APC rates are based on a “case mix” formula, so insurers should pay the actual fee schedule reimbursement amount, instead of a higher or lower reimbursement amount a medical provider might bill

Section Four: Other Ways of Paying

Not every charge on a WC bill goes through either the MS-DRG or APC reimbursement process. Dependent upon the type of facility and/or the nature of the service, procedure or supply, there can be other ways of paying for a WC bill. For example:

- Inpatient rehabilitation services are paid at 75% of the usual and customary charges***
- DME, prosthetics & orthotics (not implantables) are paid at 75% of the usual and customary charges***
- Ambulance services are to be reimbursed based on the “(d) Montana Ambulance Fee Schedule” within the Montana Facility Fee Schedule. “Urban areas” in Montana are defined as Billings, Great Falls, and Missoula. Only Status Indicator (SI) “A” codes for Ambulance-related services are to be reimbursed.**

***In Montana “usual and customary” means the provider’s normal charges for a service, and does not include state or regional database information purporting to be usual and customary**

Section Four: Other Ways of Paying

The following two lists represent the only current Acute Care Hospitals and Ambulatory Surgery Centers Reimbursed by the MS-DRG or APC process

Hospitals

- Advanced Care Hospital of MT, Billings
- Benefis Healthcare, Great Falls
- Bozeman Deaconess, Bozeman
- Central Montana, Lewistown
- Central Montana Surgery Hospital, Gt Falls
- Community Medical Center, Missoula
- Deaconess Medical Center, Billings
- Healthcenter Northwest, Kalispell
- Northern Montana, Havre
- Roundup Memorial, Roundup
- St James Community, Butte
- St. Patrick, Missoula
- St. Peter's Community, Helena
- St. Vincent Hospital, Billings

ASCs

- Big Sky Surgery Center, Missoula
- Billings Cataract & Laser Surgicenter, Billings
- Great Falls Clinic Surgery Center, Great Falls
- Helena Surgicenter, Helena
- Missoula Bone & Joint Surgery Center, Missoula
- Northern Rockies Surgicenter, Billings
- Orthopedic Surgery Center, Kalispell
- Providence Surgery Center, Missoula
- Rocky Mountain Eye Surgery Center, Missoula
- Rocky Mountain Surgical Center, Bozeman
- Same Day Surgery Center, Bozeman
- Summit Surgery Center, Butte
- The Eye Surgicenter, Billings
- Yellowstone Surgery Center, Billings

Section Five: Other Resources

In 2009 CMS published an 8 page electronic fact sheet on the UB-04 form, including a line-by-line explanation of the purpose of all of the form's sections and purposes. It can be found at:

http://www.cms.hhs.gov/MLNProducts/downloads/ub04_fact_sheet.pdf

A much more detailed explanation of the UB-04 form is provided in the CMS publication Medicare Claims Processing Manual, Chapter 25 - Completing and Processing the Form, CMS-1450 Data Set (126 pages).

Unit Two: Using the UB-04 Understanding Montana Workers' Compensation (WC) Facility Fee Schedule

A Power Point educational module created by the Montana Department of Labor (DLI) in March, 2009. Actual regulations in the Administrative Rules of Montana, of course, take precedence in case of any misstatements in this educational module.

The End